J. DUDLEY GOODLETTE
Chairman

DENNIS L. JONES
Chairman

JOINT SELECT COMMITTEE ON NURSING HOMES

Monday, March 1, 2004
10:00 a.m. – 11:15 a.m.
212 Knott Building

Committee Meeting Packet

DENNIS L. JONES
Chairman

THE FLORIDA LEGISLATURE

JOINT SELECT COMMITTEE ON NURSING HOMES

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J. DUDLEY GOODLETTE
Chairman

Agenda

March 1, 2004
212 Knott Building
10:00 a.m.

I. Call to order/Roll call

II. Opening remarks by Representative Goodlette and Senator Jones

III. Discussion and consideration of the final report of the committee

IV. Closing remarks and adjourn

Report of the Joint Select Committee on Nursing Homes
March 1, 2004

Introduction

In November 2003, the Speaker of the House of Representatives and the President of the Senate re-appointed the Joint Select Committee on Nursing Homes. The Speaker and the President asked the Committee to reconsider issues regarding the continuing liability insurance and lawsuit crisis facing Florida's long-term care facilities and to assess the impact of the reforms contained in CS/CS/CS/SB 1202 (2001).[1] The following is the report of the Committee.

Background

The 2001 Florida Legislature enacted landmark legislation, SB 1202, to deal with quality of care, tort reform, and insurance coverage in the nursing home industry. The bill required an increase in staffing in nursing homes over a three-year period, strengthened regulatory enforcement and quality oversight, established risk management and adverse incident reporting in nursing homes, required Medicaid reimbursement rebasing and full funding of direct patient care, provided significant tort reform, required nursing homes to maintain liability insurance coverage at all times, and required the Agency for Health Care Administration (AHCA) to seek a federal Medicaid waiver to use Medicaid funds to create and operate a long-term care risk-retention group for self-insurance purposes. The Legislature appropriated more than $70 million in new funding to implement the provisions of SB 1202.

In February 2002, the Speaker of the House of Representatives appointed the House Select Committee on Liability Insurance for Long-Term Care Facilities, in response to concerns of representatives of the long-term care industry regarding the high costs and unavailability of the required liability insurance coverage. The Select Committee concluded that there was no consensus among the various organizations and interest groups participating in the debate over the existence or nature of a specific crisis in the nursing home industry.

In December 2002, the Speaker of the House of Representatives and the President of the Senate appointed a Joint Select Committee on Nursing Homes to address the continuing crisis facing Florida's nursing homes in both obtaining and maintaining adequate insurance coverage. The Committee made a number of recommendations which were not adopted by the 2003 Legislature.

[1] CS/CS/CS/SB 1202 will be cited as SB 1202.

Methodology

The Joint Select Committee on Nursing Homes held five meetings during the period December 2003 through March 2004. Committee members, House and Senate staff, and other interested individuals and groups compiled an extensive list of questions.[2] These questions formed the framework for much of the discussion. Prior to each meeting, the Committee submitted pertinent subsets of the questions to the state agencies that regulate nursing homes and to the stakeholders and presenters who would address the Committee.

The Committee meetings were structured to allow the Committee to hear directly from participants in the delivery of, and litigation surrounding, nursing home care, as well as from associations and representatives of the various stakeholders in the debate. The Committee used a panel format:

- The Committee began each of the meetings with presentations of factual information from state agencies in response to the Committee's written questions.
- These presentations were followed by panel discussions featuring individuals with direct experience in the issues under consideration; panelists were selected to represent divergent viewpoints in order to produce a point-counterpoint discussion and provoke debate on complex questions.
- The Committee followed the expert panels with a combination of public testimony and invited speakers.
- The Committee received extensive written correspondence on the issues from the public.

Throughout the meeting process and deliberations, the Committee made an effort to ensure that the various stakeholders were given the opportunity to fully articulate their points of view.

The Committee heard testimony from a wide variety of interests: for-profit and not-for-profit providers in the nursing home industry; regulators at the Agency for Health Care Administration (AHCA); representatives of the Office of Insurance Regulation (OIR) at the Department of Financial Services; the Office of the State Long-Term Care Ombudsman; insurance companies; plaintiff and defense attorneys; Certified Nursing Assistants who work in nursing homes; representatives of consumers, including AARP, the National Citizens' Coalition for Nursing Home Reform, the Coalition to Protect America's Elders, and the Florida Life Care Residents Association; representatives of nursing home residents; and family caregivers.

[2] See attachment A.

Findings

Liability Insurance: Availability, Affordability, and Coverage

The Long-Term Care Risk Retention Group
In 2002 the Legislature appropriated $6 million to the Long-Term Care Risk Retention Group (RRG) in the form of a surplus loan for the capitalization of an insurance company to be owned by long-term care facilities in Florida. The purpose of the RRG is to provide legitimate, affordable, and stable professional liability coverage to long-term care facilities in the state.

As of January 15, 2004, the RRG has 182 policy holders. Of the 182, two are skilled nursing facilities, four are continuing care retirement communities, and 176 are assisted living facilities.[3] To date, the RRG has received approximately 30 incident reports with the potential to become claims, but no claims have been filed yet.

One of the key issues facing the Long-Term Care Risk Retention Group is that its product has been less competitive in the marketplace, due to the fact that it must pay back to the state a $6 million dollar surplus loan within three years from receiving its Florida Certificate of Authority. The repayment of the state loan is accomplished by collecting a capitalization charge from Long-Term Care (LTC) facilities upon their becoming an insured facility under the program. The capitalization charge is collected from member facilities over a 3-year period, and is in addition to the premium a facility pays for receiving insurance coverage.

The RRG testified that insurance market conditions are driven in large part by Florida laws which require that skilled nursing facilities carry professional liability coverage. Because state law does not require specific coverage types or amounts, and due to the additional capitalization cost of the RRG product, many skilled nursing facilities have chosen to carry the least amount of general and professional liability insurance available. As a consequence, facilities have been sued for professional liability claims and failed to even defend the case.

There has been discussion that an alternative plan for the RRG capitalization structure (such as extending the repayment period) could lessen the burden of the loan repayment, thereby lowering the capitalization charge being collected from present and future LTC facilities.

Insurance Availability
In order to find out about current availability of long-term-care liability insurance in Florida, the Committee solicited information from OIR within the Department of Financial Services, which is responsible for regulating insurance in Florida. At the Committee's request, OIR re-evaluated the liability insurance market and reported that there has been no appreciable change in the availability of private liability insurance over

[3] Risk Retention Group. 2004. All Submission Report, January 15, 2004.

the past year. Twenty-one admitted insurance entities that once offered, or now offer, professional liability coverage for nursing homes were surveyed by OIR. Six of those entities currently offer coverage. Nine surplus lines carriers have provided 54 professional liability policies in the past year. Representatives of insurance carriers that stopped providing coverage in Florida told OIR that they are waiting until there are more reliable indicators of risk nationwide to re-enter the market.

The Committee heard testimony from the Property Casualty Insurers Association of America (PCI) on the availability of liability insurance. PCI reported that from an underwriting perspective, determining loss potential is critical. Underwriters review past loss experience, state and federal inspection reports, and quality indexes assigned by state health departments. The frequency of lawsuits and the severity of judgments determine an insurer's interest in writing a class of business. Insurers need to be able to predict and quantify loss patterns with some certainty, but in Florida insurers are unable to do so. According to PCI, this unpredictability is a product of the legal environment.

The Committee also heard testimony from an insurance broker for Seitlin Insurance who reported that, since 1986, the availability of nursing home insurance in Florida has diminished. In 1986, Hartford Insurance lost a case which resulted in a large jury verdict, and within two years, Hartford stopped writing policies in Florida. St. Paul, Continental, and Cigna, the state's other large insurers, also exited the state. Since the passage of SB 1202, changes have occurred at the retail level to fill the void created by this exodus, including:

- Finite policies have become widely available.
- Captive insurers that either represent a single entity or group have been established.
- The RRG was established.
- Offshore retention-type policies exist.

Seitlin Insurance currently insures about 150 facilities in Florida, mostly small operators that do not have bond requirements for liability coverage; the company also sells finite policies in which the defense costs are within the limits of the policy. These policies typically have a higher premium than the amount of coverage. The Seitlin representative did not foresee insurers providing nursing home coverage in Florida, citing data from the AON studies that show increasing costs and claims as a deterrent to companies entering the market.

Attorneys for the nursing home industry testified that since the passage of SB 1202, nursing homes have less ability to get liability insurance, which means they are leaving Florida.

The Academy of Florida Trial Lawyers suggested that the [un]availability of insurance is a national problem, and that self-insurance, the RRG, and offerings by both admitted carriers and surplus lines carriers are available and being used by nursing homes in Florida. There is no evidence that any nursing homes have been closed solely as a result of failure to obtain insurance.

The Academy suggested that the insurance market has been unable to respond to SB 1202 because the state is still in a hard insurance market, as evidenced by workers' compensation, medical malpractice, and other lines of insurance, although there are some indicators that the market will turn upward soon; and, it was understood that it would be 3 to 5 years before the industry would have the data to determine what impact passage of the bill would have. The Academy cited the AON report provided to the Committee, which claims that it takes 10 to 11 years for all claims from incidents occurring during a year of operation to be closed and actual costs are known.

According to the Academy, until now, many nursing home cases were being brought under the old law, which does not include several of the frequency and severity reducers in place today. The Academy believes that insurers need to see loss patterns—not just one year of data under the new law—to rate a market.

Insurance Coverage and Affordability

In order to find out about current liability insurance coverage, the Committee solicited information from AHCA, which regulates nursing homes and collects information about nursing homes and insurance coverage as part of its nursing home licensure requirements. AHCA maintains a list of Florida nursing homes, names of insurance entities, and amounts of coverage per licensee. AHCA reported that this information does not, however, answer the question about whether the coverage purchased by nursing homes is adequate. Since some policies are issued to a stand-alone nursing home and other policies are issued to a group of facilities, it is not possible to determine from the data supplied to AHCA how much liability coverage a single nursing home might have.

The RRG reports that excess and surplus lines carriers are offering professional liability coverage to nursing facilities with finite limits in the range of $25,000 to $50,000 for a single occurrence in order to meet the coverage requirements of SB 1202. They state that the excess and surplus lines carriers are taking advantage of the requirements by structuring their low limits policies in such a way that they are taking no risk of loss on the policy. When a serious claim occurs, these insurers pay the low limit amount offered under the policy (for example, $25,000) and keep any premium over and above the policy limit the insureds have paid as pure profit (for example, the difference between a premium of $32,000 and the policy limit of $25,000).

Accordingly, these policies provide no meaningful coverage in the event of a legitimate claim by a resident. The RRG recommended that the Legislature require that all long-term care facilities carry aggregate professional liability coverage with a minimum coverage amount (which could be as low as $300,000). This requirement would prevent excess and surplus insurers from offering single occurrence policies for the purpose of "gaming" state law and provide meaningful coverage for legitimate claims.

The Committee invited nursing home representatives to discuss their experience with insurance and liability protection. These facilities represented a broad cross-section of the nursing home industry in the state: non-profit nursing homes, non-profit Continuing Care Retirement Communities, family-owned for profit nursing homes, Florida-based

multi-facility chains, and a publicly-traded multi-state chain. These representatives consistently discussed the difficulty in getting acceptable insurance coverage for Florida nursing homes. For example, to cover potential liability, a representative of Manor Care testified that they have put in place a complex insurance package with European underwriters with a deductible of $5 million per case. Manor Care claims that they are fortunate to have the financial stability to cover the deductibles and maintain what amounts to catastrophic coverage.

Similarly, a representative of Moorings Park Continuing Care Retirement Community testified that it is insured through Lloyd's of London for a maximum of $3 million, with a $250,000 deductible and a $225,000 premium. This policy has been in effect since 2001, when Moorings Park's traditional insurer left the market. At that time, without ever having been in a lawsuit, Moorings Park's coverage decreased, but its deductible and premium more than tripled. According to Moorings Park, its liability premiums have increased an average of 75 percent per year over the last three years. The facility is financed with bonds, and the bond covenants require that the facility maintain a specified amount of liability coverage. The premium cost equates to more than $600 per year per resident, and residents bear the cost.

Another example of the high cost of coverage was presented by a representative of River Garden Hebrew Home. River Garden is a 180 bed not-for-profit charitable nursing home in Jacksonville, Florida, that has been unable to get traditional insurance despite its being a Gold Seal facility under s. 400.235, F.S. It is insured through Lloyds of London with a policy that has a $100,000 deductible for $500,000 in coverage and an annual premium of $340,000.

Representatives of nursing homes suggested that more meaningful and effective tort reform is critically needed to enable insurers to predict losses more accurately and to price their services accordingly. As long as insurers are unable to measure the frequency and severity of losses, Florida is not going to see a change from today's situation where affordable insurance is non-existent. One nursing home representative also suggested that the Legislature should not mandate a required amount of insurance coverage or financial responsibility until affordable insurance is available in Florida.

A representative of the Florida Health Care Association (FHCA), representing the for-profit nursing homes in Florida, testified that insurance liability coverage is either unaffordable (through the RRG) or available only in limited amounts from surplus lines carriers. The latter compliance policies meet statutory requirements for coverage, but their low limits provide inadequate protection for facilities and their residents.

A representative of the Alliance for Quality Health Care, which also represents the nursing home industry, provided similar testimony, discussing the lack of insurance available for nursing homes. The Alliance testified that only the largest nursing home providers are able to self-insure, with the vast majority of nursing homes resorting to compliance policies, and that some homes carry no insurance at all.

In testimony before the Committee, a representative of the Florida Association of Homes for the Aging (FAHA) agreed that nursing homes should purchase a reasonable amount of liability insurance or meet a certain amount of financial responsibility. However, given the $300 million in proposed Medicaid cuts for nursing homes in the Governor's budget recommendations (see section on Medicaid Reimbursement), FAHA does not believe that the Legislature can responsibly impose a specific insurance or financial responsibility mandate. FAHA suggests that if a minimum amount of insurance is mandated, it must be accompanied by new funding in the form of a Medicaid pass-through to cover the cost.

An AARP representative also provided testimony on liability insurance availability and coverage. According to AARP, many nursing homes have adopted a corporate structure that limits their liability by stripping the licensee of its assets and procuring a compliance insurance policy to meet minimum regulatory requirements.

The Litigation Environment

The Committee heard testimony regarding litigation from the nursing homes' perspective, the insurers' perspective, and the resident's perspective.

Nursing Home Perspective
Attorneys for the nursing home industry claim that because few facilities have appropriate insurance coverage, facilities that do carry coverage become targets for litigation, even if the total number and severity of claims have decreased since the passage of SB 1202. According to the attorneys representing nursing homes, large insurance companies that previously wrote liability policies for nursing homes in Florida have all left the state "after all the premiums [they collected] were paid out in claims." Because not-for-profit nursing homes have insurance coverage, they are now subject to more lawsuits. Despite the excellent quality of care they provide, the number of suits filed against them have increased.

Attorneys for the nursing home industry also reported that the number of pre-suit discovery letters inquiring about the existence and coverage limits of nursing home insurance policies has not decreased since the passage of SB 1202, but that the number of suits actually filed and Notices of Intent are decreasing.

An explanation given for the decrease in lawsuits is that: (1) responses to letters inquiring about existence and coverage limits shows so little coverage that the plaintiff bar won't file suit, or (2) if a facility has, for example, $50,000 in coverage, the case may settle pre-suit because it is settled within the policy limits. Large insurance limits provide an incentive to bring suit, even in light of increases in quality of care.

The consensus from the attorneys representing the nursing home industry who testified is that SB 1202 has been successful in eliminating add-on attorney fees, and that this has the effect of providing some check on litigation. Add-on fees were not tied to results. The dispute resolution process is now more streamlined, with rapid moves to resolution of

cases. Some of this rapid movement to settlement is attributable to SB 1202, but it is mostly due to the lack of insurance coverage.

There were two suggestions for addressing the issue. First, nursing homes should not be treated differently than hospitals. In a nursing home, a nurse is subject to a suit for alleged malpractice only under ch. 400, F.S. In a hospital, that same nurse is subject to the requirements of ch. 766, F.S., with caps on liability and the possibility of arbitration. Second, a nursing home should be considered a health care provider. The reason there are few insurance providers is because they cannot predict claims. The law needs to be revised so that plaintiffs get compensated and nursing homes stay in business. It was suggested that revisions to ch. 400, F.S., similar to the changes made in the medical malpractice arena, will allow insurers to predict claims and thus return to the market in Florida.

A representative of one of the large nationwide nursing home chains that operates nursing homes in Florida, testified that the liability costs they are incurring are not related to quality, but rather the high cost of litigation is largely because of the litigious environment in Florida that makes even those facilities that provide high-quality care vulnerable to large jury awards.

The nursing home associations provided testimony regarding litigation as well. A representative of FHCA testified that despite the quality improvements and litigation reform put in place by SB 1202, the rate of claims experienced by the state's nursing homes has not decreased. The FHCA representative suggested that SB 1202 does not address the industry's particular vulnerability to lawsuits because nursing homes care for a population of people living out the final stages of their lives and in which accidents occur. This leaves nursing homes open to extreme awards by juries swayed by emotional arguments. The FHCA representative testified that currently, without caps on non-economic damages, the severity of claims remains unchecked and insurers cannot make actuarial projections to write sound liability insurance.

A representative of the Alliance for Quality Health Care suggested, as part of a comprehensive approach, that a voluntary binding arbitration system should be enacted similar to that which is currently in effect for physicians and hospitals, including a limitation of applying such a system only to the provision of nursing home health care services. The Alliance also suggested that arbitration caps of $250,000 when both parties agree to arbitration, and $350,000 when the defendant requests arbitration but the plaintiff goes to trial, should be enacted and adjusted for inflation. In addition, limits should be placed on total non-economic liability of those invoking voluntary arbitration to the limits set forth for all claimants arising out of the same incident. Finally, the Alliance suggested the adoption of a nursing home health care review panel. The panel would be structured so that timely professional opinions would be rendered on whether there was a breach of a standard of care or negligence. A timely and non-binding review panel would not impair a claimant's access to the courts, and would discourage non-meritorious litigation as the panel's recommendations would be admissible in subsequent proceedings.

A representative of the Florida Association of Homes for the Aging, representing the not-for-profit nursing homes in Florida, was more optimistic about SB 1202, suggesting that passage of SB 1202 provided balanced tort reform coupled with staffing mandates and other quality improvement measures that seem to be paying off. FAHA is not averse to additional tort reform that builds on the changes adopted for nursing homes as part of SB 1202, including the creation of a voluntary pre-suit panel to review claims and determine if a facility was negligent in following accepted standards of care. The panel's findings would not be binding, but they could be used as evidence if a case proceeds to arbitration or trial. FAHA also supports a cap on non-economic damages in conjunction with binding arbitration provided it is no higher than the $250,000 ($350,000 if offer at arbitration is refused and case proceeds to trial) in effect for hospitals.

Insurer Perspective
A representative of the Property Casualty Insurers Association of America (PCI) testified that the long-term health care reform provisions of SB 1202 addressed specific underwriting concerns. The requirement to have nursing homes implement risk management programs, they believe, will help to improve the quality of nursing home care. However, stronger resident care measures alone will not remedy nursing home litigation. According to PCI, SB 1202, when initially introduced, mirrored the medical malpractice statute, but the bill as enacted lacked many of those changes initially envisioned. In addition, Florida's patient rights laws provide a lower threshold of proof than most states and give rise to broader causes of action. PCI believes that until further litigation reform is enacted, it is doubtful that property and casualty insurers writing nursing home insurance will view Florida as an attractive market.

The representative of PCI testified that it supports alternatives to traditional legal dispute resolution, viewing them as effective ways to control excessive costs resulting from civil litigation. According to PCI, arbitration often results in an efficient and equitable disposition of claims. However, the representative of PCI testified that legislation allowing parties to opt out of signatory arbitration agreements should not be allowed and the ability to award punitive damages and attorney fees should remain outside the purview of arbitrators.

Resident Perspective
Attorneys representing nursing home residents testified that there is statistical evidence that SB 1202 is working. According to these attorneys, no large punitive damage awards have occurred since passage of SB 1202, and staffing levels have dramatically increased quality. As a result, law firms are turning down cases because the injuries are not as severe before passage of SB 1202.

A representative of the Academy of Florida Trial Lawyers testified that during deliberations on SB 1202, it was understood that its effects would be realized in three to five years, i.e., May 2006 to May 2008, and suggested that the Legislature re-examine this issue beginning in 2006, making no changes until then. As to frequency of lawsuits, the Academy believes that the only objective information available thus far is from

AHCA. The most recent information provided to the Committee by ACHA shows that the frequency of lawsuits is down. Notices of intent are trending downward also, and the majority of notices of intent never result in a lawsuit; only 20 percent do.

A representative of AARP testified that a significant number of nursing home residents who have been negligently injured will never be compensated because they have no meaningful remedy through the courts due to low value "wasting" or compliance policies as the insurance vehicle of choice or necessity for many nursing homes. Many nursing home agreements include binding arbitration clauses with very low caps on damages which must be signed as a prerequisite to admission. Any action that may be taken to address immediate nursing home liability and quality problems must be comprehensive, and must preserve all residents' access to courts by assuring a meaningful remedy now and in the long-run. Those residents who need immediate relief may get that by the Legislature addressing increased financial responsibility, penetrating the judgment-proof business model, forbidding binding arbitration agreements in admissions contracts, and exploring tort changes that may support greater financial responsibility and ability to pay a claim.

Quality of Care

There was a general consensus among the various stakeholders that the quality of care in Florida nursing homes is improving.

The Survey Process
Nursing homes are surveyed by AHCA to determine compliance with state and federal regulations. Each nursing home receives a full survey on average every twelve months, although some may be surveyed as frequently as every six months. A full survey is composed of many tasks and relies on a case-mix stratified sample of residents to gather information about the facility's compliance with regulatory requirements. The nursing home survey process focuses on compliance with federal requirements for Medicare and Medicaid that are also required for state licensure. In addition to full surveys, AHCA investigates consumer complaints filed against nursing homes.

The Committee heard testimony about the quality of care in nursing homes. Almost every speaker addressing the Committee on quality issues reiterated the positive effects of SB 1202 in increasing the number of staff present in nursing homes. There was consistent testimony that the quality of care was improving and that the improvement was directly related to the increase in the number of staff that is required in nursing homes.

In general, during testimony regarding quality of care in nursing homes, the following points of view were expressed:

- In terms of quality, SB 1202 is working, and staffing increases must be continued and fully funded.
- Since the implementation of SB 1202, the number of deficiencies cited at the more severe levels has gone down.

- The agency is using its regulatory authority to cite homes that are not meeting resident's needs, even if the home is meeting the state-mandated minimum staffing requirement.
- The severity of deficiencies cited by AHCA on surveys has decreased, indicating that residents are less often experiencing quality of care deficiencies that are widespread in the facility or pose immediate jeopardy.
- Turnover of direct care staff has been reduced. Turnover was an indicator of quality that policy makers considered in developing SB 1202 and its predecessor legislation on nursing home reform.
- Consumer information is more available, but AHCA's Watch List and STAR rating system need to be refined to allow consumers to more easily identify problem nursing homes and chronic under-performers.
- Medicaid should reimburse nursing homes for the increased costs associated with providing care mandated by law.
- Continually or chronically poor-performing facilities must be closed or terminated from participation in Medicaid and Medicare.

Nursing Home Perspective

Representatives of both nursing home industry trade associations, Florida Health Care Association (FHCA) and the Florida Association of Homes for the Aging (FAHA), reported that the quality components associated with SB 1202 were working. They reported that the required surveys conducted by AHCA have found fewer high level deficiencies since the implementation of the bill. Analyzing that survey data, they reported to the Committee that the majority of Florida nursing homes are performing better than the national average on quality indicators related to use of restraints, pain, delirium, and resident's ability to walk; that there has been a 33 percent reduction in the average number of deficiencies per survey between 2002 and September 2003; and that nursing homes are in compliance with 96 percent of the required federal standards.

In FHCA's evaluation of all of the states' standards for staffing, Florida has the highest nursing home staffing standards in the nation, and those standards are being met or exceeded. As a further sign of the success of increased staffing standard, there has been a reduction in turnover among direct care staff. Turnover among Certified Nursing Assistants (CNAs) has declined from 72 percent in 2001 to 61 percent in 2002.

The representative of the Alliance for Quality Health Care testified that the quality of care staffing increases planned in SB 1202 should be funded by the Legislature and go into effect in May 2004 as planned.

The representative of River Garden Hebrew Home recommended that CNAs should be offered additional training in geriatric care in the nursing home setting and be provided an opportunity to specialize in geriatric care. Bills have been introduced in both the Senate and the House to accomplish this goal.

Representatives of nursing homes in the state suggested re-examining the criteria for identifying poor performers, specifically the violations resulting in placement on the

Nursing Home Watch List, and focusing on these facilities so that high-quality facilities are not punished for actions taken by poor-performing facilities.

Staff Perspective
Certified Nursing Assistants from the Service Employees International Union also testified that it was their experience that the increased staff was helping to reduce workloads. The CNAs felt that they were better able to meet the needs of the residents that they cared for and about. CNAs also commented that decreased turnover was good for patient care. In addition, they testified that a career ladder, improved pay, and affordable health care benefits are important for retaining high quality CNAs.

Consumer Perspective
A number of consumers and consumer groups presented testimony to the Committee. These were AARP, the National Citizen's Coalition for Nursing Home Reform, the Florida Alliance for Retired Americans, the Older Women's League of Southeast Florida, CCRC Residents, and affected individuals.

Representatives of these consumers testified that the SB 1202 requirement for increased staffing and other quality improvements were having a beneficial effect on patient care. AARP and others urged continued implementation of the staffing increases. The representative of AARP told the Committee that it is critical that the final phase of staffing from that bill be implemented; otherwise, the data demonstrates that residents will be harmed.

Representatives of AARP and the National Citizen's Coalition for Nursing Home Reform also focused on the continued problem of nursing facilities that do not meet minimum standards, are cited by the agency during a survey, and improve their operations in the short-term only to avoid termination or closure. They reported that they have been working with AHCA and with industry representatives to develop a plan that would allow AHCA to take sufficient regulatory action to end this cycle of improvement and decline in order to effect either consistent improvement in quality or closure of a facility. AARP testified that competitive market forces do not operate in the nursing home arena, and there is little real consumer choice. People rarely shop for nursing homes; rather, they are placed in homes usually when they are being discharged from a hospital at a time and in circumstances that do not allow for comparison shopping.

The Long-term Care Ombudsman likewise reported a change in the nature of complaints received. Complaints related to inadequate staffing are no longer the most frequent complaints received.[4]

Medicaid Reimbursement

The Committee heard testimony regarding several Medicaid nursing home reimbursement issues. Since Medicaid is the primary payer for nursing home care,

[4] The Ombudsman summarized that trend in Chart 8 at the end of this Report.

changes in reimbursement policies can have a significant impact on Florida's nursing homes. The continuing challenge for policymakers in the coming years will be to improve nursing home quality while minimizing taxpayer expenditures.

Nursing homes argue that the Medicaid program can encourage them to admit more Medicaid residents and provide higher quality care if the program pays a higher reimbursement rate for Medicaid resident care. A representative of FHCA testified that limits on Medicaid nursing home reimbursement have produced a situation in which 86 percent of Florida nursing homes are paid less than their allowable Medicaid costs. The state's funding policies have resulted in a reimbursement plan that is complex and unresponsive to the increasingly intense needs of nursing home residents and the facilities committed to providing quality care to them.

Agency for Health Care Administration Rule and State Plan Amendment
Nursing homes expressed concern about an AHCA proposed rule amendment and state plan amendment that would eliminate inflation and new cost report adjustments for the time period March 1, 2004 to June 30, 2004. This rule amendment has been challenged by the industry and is currently stalled. The estimated savings to the Medicaid program was projected to be $24,403,102 in total funds, or $9,302,462 in General Revenue, based on a March 1, 2004, effective date. The rule amendment and state plan amendment have been withdrawn.

Nursing Home Rate Freeze
Currently, nursing home reimbursement rates are recalculated on January 1 and July 1 every year, using the most current cost report information available under the Florida Title XIX Long-Term Care Reimbursement Plan. Rates are set at these periodic increments to adjust institutional reimbursement for changes in base costs, acuity levels, utilization, and inflation that are constantly at play in the health care industry. The Governor's Executive Budget recommends freezing nursing home reimbursement rates at the January 1, 2004 level. The Governor's proposal would eliminate the July 1, 2004 and January 1, 2005 rate recalculations, maintaining rates at the January 1, 2004 level until the July 1, 2005 recalculation. However, there is no guarantee that there will be an automatic rate recalculation July 1, 2005. This will be up to the Legislature to decide. Expenditure growth is capped using a target rate limitation system (base rate growth limited each year by a multiple of inflation). The estimated savings to the Medicaid program from the Governor's recommendation for fiscal year 2004-2005 would be $201,041,102.

Nursing Home Staffing Increases
Currently, the direct care portion of the Medicaid nursing home reimbursement rate includes a payment for a direct care Certified Nursing Assistant staffing level of 2.6 hours per resident per day. Beginning May 1, 2004,[5] this staffing level will increase to 2.9 hours per resident per day.

[5] This was to go into effect January 1, 2004, but the 2003 Legislature adjusted the effective date to May 1, 2004.

The Governor's budget eliminated the staffing increase to 2.9 hours effective July 1, 2004. The savings for FY 2004-2005 would be $61,544,269 ($25,294,694 in GR and $36,249,575 in Trust).

Medicaid Bed Hold Policy

Medicaid has a bed hold policy to ensure that residents of nursing homes will be assured of a bed in their respective facilities when they return from hospitalization or therapeutic leave. This policy assists with continuity of care and eliminates the additional burden placed on families to find a new nursing home upon discharge from the hospital after a short stay. Currently, Medicaid reimburses for bed hold days in nursing homes and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). Payments for bed hold days are optional pursuant to federal law (not required under Title XIX of the Social Security Act). Reimbursement for bed hold days has been permitted under Florida's Medicaid plan since 1978.

For nursing homes, Medicaid currently pays 100 percent of the Medicaid daily nursing home rate to reserve a bed for up to 8 days for each hospital stay per resident. Additionally, current Medicaid policy allows for payment of bed hold days if the resident leaves the facility to go to a "family-type setting" for a specified length of time. For nursing facilities, these bed hold days are restricted to 16 days per resident for each state fiscal year.

To be eligible for bed hold reimbursement under Medicaid, nursing facilities must demonstrate that they had at least an 80 percent Medicaid occupancy rate in the previous quarter of the year. The average nursing home occupancy rate statewide for June 2003 was 87.1 percent.

Other states with bed hold policies have more strict reimbursement requirements. The nursing facilities must have had higher occupancy rates to be reimbursed; reimburse for fewer days; and/or reimburse for rooms at a reduced daily rate.

The Committee heard testimony that savings from changing the Medicaid reimbursement policy for bed hold in nursing homes could be used to fund the CNA staffing increase.

Medicaid Estate Planning

The Committee expressed concern regarding the practice of Medicaid estate planning, whereby individuals and their families structure their assets in order to qualify for state assistance for nursing home care through Medicaid. Federal and state laws allow the use of trusts in which an eligible elderly individual places income in excess of Medicaid minimums into an irrevocable trust. The proceeds of the trust accrue to the state upon the individual's death.

However, members were particularly concerned about individuals who have sufficient liquid assets to cover the costs of care in nursing homes, but divest themselves of these assets to gain Medicaid eligibility for nursing home care, despite federal criminal

penalties for knowingly and willfully counseling or assisting an individual to dispose of assets in order for the individual to become eligible for medical assistance.

Medicaid Provider Agreements
An AARP representative suggested using the cancellation of a nursing home's Medicaid agreement as a way to focus on improving quality in poor performing facilities. If quality did not improve, the nursing home could be eliminated from the Medicaid program. Before terminating a nursing home from the Medicaid program, the nursing home could be given the option of participating in the Medicaid "Up or Out" Program which would provide the nursing home with the opportunity to improve quality to a satisfactory level. In some areas, there may be no other institutional or community alternatives for people other than the nursing home. Efforts should be made to improve the quality of care in these facilities rather than terminating them from the Medicaid program.

Conclusions

In the testimony the Committee received, there was consensus that the quality of care in Florida nursing homes is improving, in large part due to the minimum staffing standards the Legislature adopted in SB 1202 during the 2001 Session. There was not, however, a consensus about whether or not lawsuits are abating due to the tort system changes contained in SB 1202. There was consensus that the long-term care liability insurance market has not yet improved.

After hearing the testimony, there is general consensus among the members of the Joint Select Committee that:

- The Legislature should consider only comprehensive reform which provides access to courts while revitalizing the insurance market and ensuring access to quality and affordable nursing home care. For instance, to ensure access to courts and in order to make compensation available to victims of nursing home abuse and neglect, nursing homes need an incentive to carry professional liability insurance at a higher level. In order to provide such incentive for nursing homes to carry a specified minimum amount of liability insurance coverage, based on a per bed calculation, the Legislature could allow those nursing homes which carry a specified minimum amount of general and professional liability insurance to utilize a voluntary binding arbitration process with caps on non-economic damages. Such an option would provide at least a specified amount of financial assets to be available to the victim, which is not currently the case.

- Data collected by the state agencies indicates that quality of care in Florida nursing homes is improving. There is a consensus that this improvement is due to the staffing standards contained in SB 1202 and that these standards are having the desired effect of increasing the amount of care nursing home residents are receiving. There was universal agreement among all sectors of the nursing home industry, including regulators, insurers, advocates, and families of nursing home residents, that the final

increase in mandatory staffing levels currently required in Florida law should be implemented and fully funded.

- The data collected by the state regarding lawsuits and recovery is insufficient, thus making it difficult for the Legislature to objectively determine whether the number of lawsuits against nursing homes is increasing or decreasing, or whether the costs of liability claims to the nursing home industry is going up or down.

- Nursing homes continue to be impacted by a combination of increasing liability insurance costs, competing demand for labor, with the consequent increase in labor costs, and limitations on state Medicaid reimbursement.

- At the Committee's request, OIR reevaluated the liability insurance market and reported that there has been no appreciable change in the availability of private liability insurance over the past year.

- General and professional liability insurance, with actual transfer-of-risk, is virtually unavailable in Florida. "Bare-bones" policies designed to provide minimal compliance with the statutory insurance requirement are available; however, the cost often exceeds the face value of the coverage offered in the policy. This situation is a crisis which threatens the continued existence of long-term care facilities in Florida.

- There is growing concern that the combination of minimal compliance liability policies and changes in nursing home corporate structures designed to limit liability have the potential of producing a situation in which an injured resident may have no hope of recovery of a legitimate claim.

- It is important that the state be able to take action against chronically poor performing nursing homes, and that nursing homes which provide chronically deficient care should be closed; however, there is no consensus as to the criteria that should be used to determine which facilities should be closed.

- Continuing Care Retirement Communities are in a unique situation. These facilities, on the whole, seem to have better quality of care; however, residents, as private purchasers of care, are forced to absorb increases in operating costs due to escalating insurance costs.

A number of Legislative actions were proposed by the individuals who testified before the Committee. These included:

Liability Insurance Availability, Affordability, and Coverage

<u>Facilities</u>

- Lengthen the time the RRG has to repay the Medicaid loan.

- Mandate a minimum aggregate level of insurance coverage, calculated on a per-bed rate.

- Require, as an ongoing condition of licensure, closed claims reporting, including details of settlement agreements.

- Require, as an ongoing condition of licensure, reporting of civil verdicts and judgments relating to medical negligence, violation of residents' rights, or wrongful death, within 30 days after filing with the clerk of the court.

- Provide additional ways for nursing homes to demonstrate financial responsibility.

- Require that insurance premiums are based on each nursing home's historical loss history/experience rating.

Individuals

- Encourage Congress to provide tax credits for people who purchase long-term care insurance.

Tort

Residents

- Develop an "informal dispute resolution" process for residents and families to dispute survey findings, similar to the one currently in place for nursing home providers.

- Eliminate binding arbitration clauses in admission contracts.

- Develop a statewide standardized nursing home admission contract.

- Require county medical examiners to inspect all bodies of all resident deaths in nursing homes to determine if autopsy should be performed.

- Amend subsection 8 of s. 768.21, F.S., the Wrongful Death Act, in order to allow for recovery of damages for lost parental companionship, instruction and guidance, and for mental pain and suffering by adult children of the decedent if there is no surviving spouse.

Facilities

- Impose a cap on recovery of non-economic damages.

- Impose reasonable caps on punitive damages and no caps on punitive damages in the most egregious cases.

- Require voluntary binding arbitration with caps on non-economic damages with or without a cap on punitive damages.

- If the nursing home contract includes an arbitration agreement, require specific notice to the family/resident.

Quality of Care

Staffing

- Implement and fully fund staffing increase for CNAs up to 2.9 hours.

- Require and fund more geriatric specialty training for CNAs.

- Fund raises for CNAs and implement performance requirements.

- Require staffing in nursing homes to be calculated by shift, rather than on a 24-hour basis, or allow nursing homes to provide staffing at the time it is needed.

- Impose a moratorium on further quality of care regulations because the increase in costs associated with their implementation is too burdensome for the industry at this time.

- Minimize paperwork to be filled out by nursing home staff in order to maximize time spent on direct care to residents.

Residents

- Strengthen and enlarge the Ombudsman program by removing the cap on the number of volunteers that may serve on each District Council.

- Revise residents' rights to allow residents or their families to install video cameras at their own expense.

- Require and fund a consumer satisfaction survey.

General

- Eliminate the one-day adverse incident report.

- Align the state and federal definitions for a nursing home deficiency.

- Expand Up-or-Out program to assist poor performing facilities to improve.

Medicaid Funding

Facilities

- Fund staffing increases.
- Modify bed-hold reimbursement policy.
- Do not cut Medicaid reimbursement for nursing homes.
- Terminate Medicaid participation of chronically poor performing nursing homes; consider allowing facilities to reapply after a specific period of time, with or without assistance through Up-or-Out program.

Leave the Status Quo

- Implement all of the provisions of CS/CS/CS/SB 1202 and give them time to work.

Other Legislation

- Support SB 1062/ HB 267 – nursing home bed conversion.
- Support SB 1472/ HB 361 – allow nursing homes to provide state group health insurance to employees.
- Support SB 492/ HB 189 which offer CNAs the ability to receive additional nursing training in geriatrics.
- Establish elder abuse statutes which would provide the State Attorney the ability to immediately prosecute individuals who neglect, abuse, or exploit the elderly.

Attachment A

Questions for the Joint Select Committee on Nursing Homes

Insurance questions:

- What would be the effect of voluntary binding arbitration on the availability of liability insurance for long-term care facilities?
- What is the current status of nursing home compliance with requirements to carry liability insurance as a condition of licensure?
- How many insurance companies are currently providing liability coverage to nursing homes in Florida? How many are authorized insurers and how many are surplus lines insurers?
- How many insurance providers have re-entered the Florida market following the passage of the SB 1202 reforms? How many have left the Florida market?
- What type of insurance coverage is currently obtained by each nursing home, i.e. authorized insurer, surplus lines insurer, risk retention group or self-insurance?
- What are the current rates for coverage? Are current rates justified? How are they calculated?
- Are current rates set based on claim experience or numbers of adverse incidents?
- What are the limits of liability coverage currently carried by Florida nursing homes?
- Does a minimum amount of general and professional liability insurance need to be set for Florida's nursing homes? Should the minimum be based on numbers of beds? If so what affect will that have on creating a competitive insurance market in Florida?
- What types of self-insurance options are available for nursing homes? Should self-insurance or large deductibles be allowable options to meet state liability insurance requirements?
- Has AHCA interpreted the requirement that nursing homes carry liability insurance to prevent self-insurance by facilities?
- What percentage of nursing homes are self-insured? Are these non-profits, or national chains?
- Should defendant nursing homes be prohibited from using money set aside to pay claims for legal defense costs similar to what was done in the medical malpractice legislation?
- How many nursing homes are covered through the state funded Risk Retention Group?
- How do the rates through the Risk Retention Group compare to rates from other liability insurers?
- What is the status of the funding provided for the Risk Retention Group?
- What is the justification for putting nursing homes and assisted living facilities in the same risk pool for purposes of setting premiums?
- Is there a difference in the claims experience (number and severity of claims) of assisted living facilities and nursing homes?
- Is there documented evidence of justified claims not being compensated because of insufficient liability insurance coverage by nursing homes?
- How long was it estimated to take for insurers to respond to the tort changes passed in SB 1202 and begin writing policies again?
- How many nursing homes have been closed by AHCA for not maintaining liability insurance?
- What is the status of nursing home insurance nationally?

- Are insurers writing policies across the nation?
- In 2000, the Florida Department of Insurance reported that all 17 insurers that reported they were exiting the Florida market were doing so as part of a national strategy. Have those insurers been contacted to get an update on their status?
- Is the lack of nursing home liability insurance a Florida problem or a national one?
- Is there evidence that national nursing home chains would purchase commercial liability insurance if it were readily available?
- Is there conclusive evidence that insurers will return to the market if additional tort reform measures are passed?
- If insurance is not readily available, do we need to look into creating a JUA for nursing homes?

Legal questions:

- What would be the effect on the number of lawsuits filed and damages which might be available, if we brought nursing homes under the same liability scheme as hospitals? Would the burden of proof change?
- Are there differences in the nature of nursing home claims which make it impossible to treat them in the same manner as we treat hospital or other medical providers?
- Is there a difference in the numbers of lawsuits against long-term care facilities since the changes in SB 1202? Is there a discernable uptrend or downtrend in the numbers of suits being filed?
- Is there a difference in the number of suits or notices of intent filed against facilities based on for-profit or not-for-profit status? Since there are many more beds in the for-profit side of the industry, can you adjust your notice and lawsuit data to reflect the relative sizes of these sectors of the long-term care industry?
- Do suits currently in the legal system relate to incidents which occurred prior to or after the passage of SB1202?
- Is there an uptrend or downtrend in the damages sought in lawsuits? As in the previous question, is there a difference in the damage amounts for suits for incidents pre and post SB 1202?
- What does AHCA data say about whether notices of intent to sue actually become lawsuits? Do you know how many of these are settled prior to court action? Do you know the amounts of these settlements?
- Should a new definition of "health care services" be created to better classify the services provided in a nursing home?
- Should nursing homes be able to use arbitration proceedings similar to those used in medical malpractice cases?
- If so, what limits should be set on non-economic damages and punitive damages?
- Should there be a maximum number of arbitration proceedings that one nursing home is allowed to participate in during a set period of time?
- What damages are available in arbitration proceedings? How are non-economic damages calculated in these proceedings? Are punitive damages available? Do the nursing homes have to admit liability? What does that admission mean? Do they have to acknowledge that their negligence caused the injury to or the death of a resident?
- Are the numbers of liability claims increasing, decreasing, or remaining constant?
- What has been the historical trend of the numbers of notices of intent to file litigation being filed with AHCA for nursing homes and assisted living facilities since passage of SB 1202?

- What has been the historical trend of the numbers of claims filed in court for nursing homes and assisted living facilities since passage of SB 1202?
- How do these numbers compare between nursing homes and assisted living facilities?
- Should insurers be required to report closed claims against nursing homes and assisted living facilities to the Office of Insurance Regulation/AHCA similar to closed claims reporting for medical malpractice?
- Should nursing homes be granted a cap on non-economic damages similar to the $750,000/ $1.5 million cap granted to hospitals during the medical malpractice special session?
- Should we create medical review panels for nursing home claims to reduce the frequency of lawsuits?
- Prior to SB 1202, were nursing home lawsuits on the rise or remaining the same?
- All of the nursing home litigation reform provisions, except for punitive damage changes, applied to incidents that occurred after May 01.
    - What percentage of cases brought between May 01 - May 02 were cases arising under the old law?
    - What percentage of cases brought between May 02 - May 03 were cases arising under the old law?
- What is the lag time between an incident happening and a notice of intent being sent to a nursing home?
- Does the fact that a notice of intent has been filed mean that a lawsuit will necessarily be filed? What percentage of the notices of intent turns into actual lawsuits?
- What is the effect of ALFs and nursing homes requiring that prospective residents agree to binding arbitration as a condition of admission?
- Have these arbitration agreements be enforced by courts?
- Are there any nursing homes or ALFs using arbitration clauses?
    - Do these clauses cap non-economic damages?
    - Do these clauses eliminate punitive damages?
    - Do these clauses eliminate access to attorney's fees, i.e., offer of judgment?
    - Do these clauses change the standard of proof?
    - Do these clauses severely limit discovery, including access to necessary records?
    - Do these clauses eliminate the constitutional right to trial by jury?
    - Do these clauses subject the resident or the family to biased arbitration panels?
- Are these arbitration clauses being required of residents who are incompetent to consent or on family members in times of distress?

Regulation of Quality of Care questions:

- Are the numbers of nursing home and ALF quality-of-care deficiency citations increasing, decreasing or staying more or less the same?
- Is the level of severity found in citations getting better or getting worse? Is the nature of the citations changing? How has the type of top 10 citations changed over the past 3 years?
- Is there a difference in the nature or severity of citations for facilities which are for-profit chains, for-profit independents, versus not-for-profit facilities?
- How do the citation rates differ by AHCA area offices?
- What effect has the increase in staffing standards had on quality of care or on deficiency citations your agency issues? Has the nature or severity of staffing citations increased or decreased?
- How does Florida's minimum staffing requirements compare with other states?

- Would it be more useful to target the quality of care monitors to the bottom 25% of facilities?
- Is there a linkage or pattern between staffing deficiency citations, adverse incidents, and lawsuits?
- How many nursing home administrators are licensed in Florida? Is this a sufficient number?
- Can a nursing home administrator work at more than one nursing home? If so, how many?
- Has there been a decline in the number of newly licensed nursing home administrators over the past three years?
- Has there been consideration for nursing home administrator recruitment incentives like those being done to address the nursing deficit?
- What are the benefits from limiting the number of nursing homes that an administrator can work at?
- Can a doctor serve as a medical director of more than one nursing home? If so, how many?
- Are nursing homes having any difficulty finding Medical Directors? If yes, what are the major reasons?
- How many nursing home administrators have been disciplined in Florida during the last 2 years? What was the nature of the violation and the discipline imposed?
- Is there a need to have more local control over the nursing home services provided to Floridians? Should we consider a residency requirement within a particular geographic distance for officers, directors, nursing directors, medical directors, and/or nursing home administrators?
- Should the minimum staffing requirements in nursing homes be raised further?
- Should a certified geriatric specialist license level be created to increase the education and training levels of nursing home caregivers? Will such a license increase retention and overall satisfaction of employees? How would nursing home residents benefit?
- What has been the historical trend of nursing home citations (both numbers and severity of citations) since the passage of SB 1202?
- What has been the historical trend of reporting of adverse incidents since the passage of SB 1202?
- What is the status of the Medicaid "Up-or-Out" pilot project and what have we learned so far from the pilot project about improving the quality of care in poor performing nursing homes?
- How have the quality-of-care monitors been functioning and what has their assessment been of the overall quality of life in nursing facilities?
- Have the long-term care ombudsmen noticed an improvement in the quality of care in nursing homes since the passage of SB 1202?
- Have all the staffing provisions passed in Senate Bill 1202 been implemented?
- Who is the primary caregiver in a nursing home and an ALF?
- What are the primary differences between a nursing home and a hospital?
- Has quality of care improved in all categories since the passage of Senate Bill 1202?
- What are the mechanisms to report and investigate elder abuse in nursing homes and ALFs?
- Are the number of complaints to the Ombudsman program increasing or decreasing? If they are increasing, what kind of resources are we providing to handle the increase?
- Does the Ombudsman program have sufficient resources to investigate complaints?
- Are family counsels being created and supported in nursing homes?

- When there is a death in a nursing home or ALF that is considered accidental or may be attributed to neglect or abuse, is it reported to the medical examiners office?
- In view of the recent fires in nursing homes and the record number of deaths, should all nursing homes be required to have adequate fire recognition and fire suppression systems?
- Should there be a statewide investigation of the ability of nursing homes to recognize and suppress fires?
- Should there be a statewide investigation of nursing home evacuation plans and their ability to safely evacuate the residents in case of fires?
- What has happened to nursing home occupancy since we capped the CONs in SB 1202?
- Last year we heard testimony that was immediately refuted by AHCA that there were 22 nursing home closures in the last 12 months. How many nursing home closures have there actually been and what were the reasons for the closure as reported to AHCA?
- What percentage of nursing home beds has been lost because of closures?
- Last year we made an exception in law that allowed continuing care retirement communities (CCRCs) to build more nursing home beds. Have CCRCs taken advantage of this exception?
- How many nursing homes have opened or re-opened in the last year?
- What have been the geographical differences in the historical trend of nursing home citations since the passage of SB 1202?
- How many Class II citations have been given for non-reporting of adverse incidents?
- What are the federal and state requirements to report and investigate elder abuse in nursing homes and ALFs?
- How does the Department of Children and Families respond to nursing facilities self-reporting of resident to resident altercations?
- What are the additional costs for the certified geriatric specialist license?

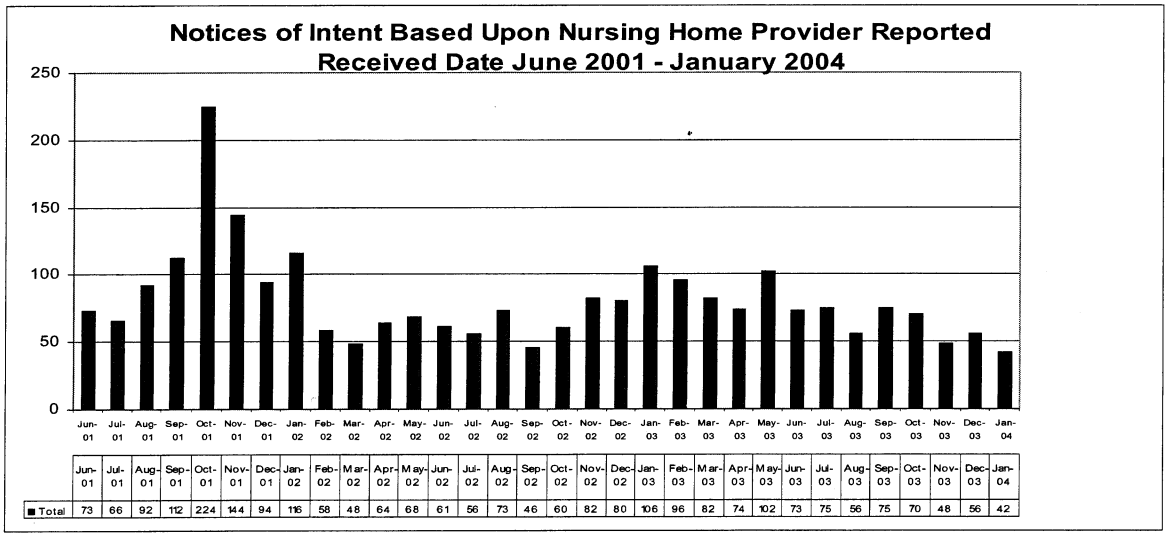
Nursing Home Reimbursement

- Does the Medicaid rate adequately cover the cost of providing care to Medicaid residents?
- What is the percentage of nursing homes whose Medicaid rate is lower than its average Medicaid cost?
- Is there a disparity in Medicaid rates between providers providing the same or identical services?
- How are nursing home liability costs reimbursed?
- Does Medicaid reimburse nursing homes to fully cover the Medicaid portion of liability insurance costs?
- Does the methodology that was adopted by AHCA for reimbursing providers for direct care costs cover expenses mandated by the Legislature?

Attachment B

AHCA Lawsuit Data

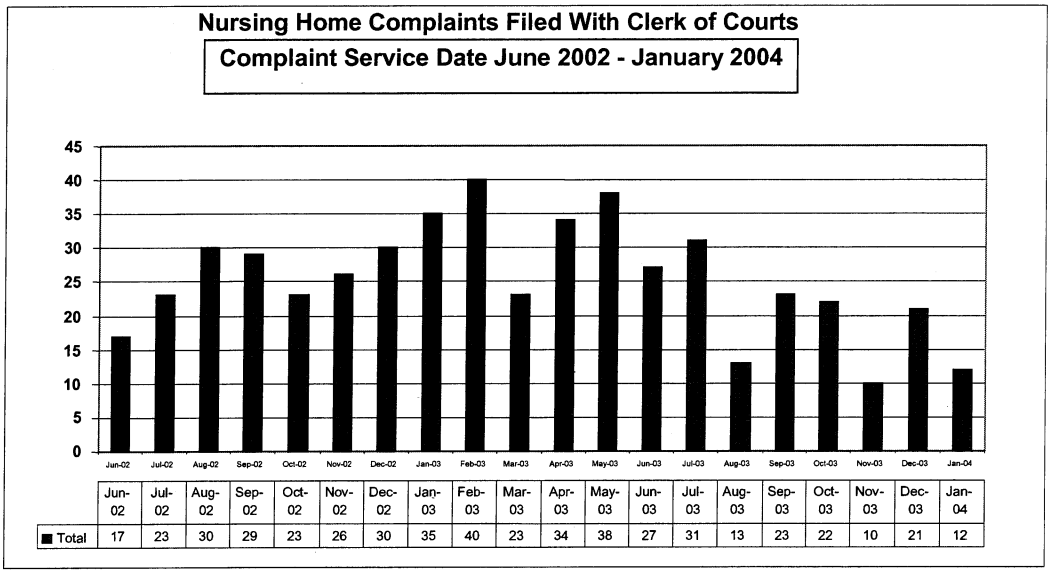
Chart 1



	Jun-01	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	Jan-04
Total	73	66	92	112	224	144	94	116	58	48	64	68	61	56	73	46	60	82	80	106	96	82	74	102	73	75	56	75	70	48	56	42

Pursuant to s. 400.0233(2), F.S., a complaint may not be filed for a period of 75 days after mailing a Notice of Intent (NOI). Accordingly, NOI data should "lead" complaints filed by a quarter. Chart 1 shows all NOIs filed since the passage of SB 1202.

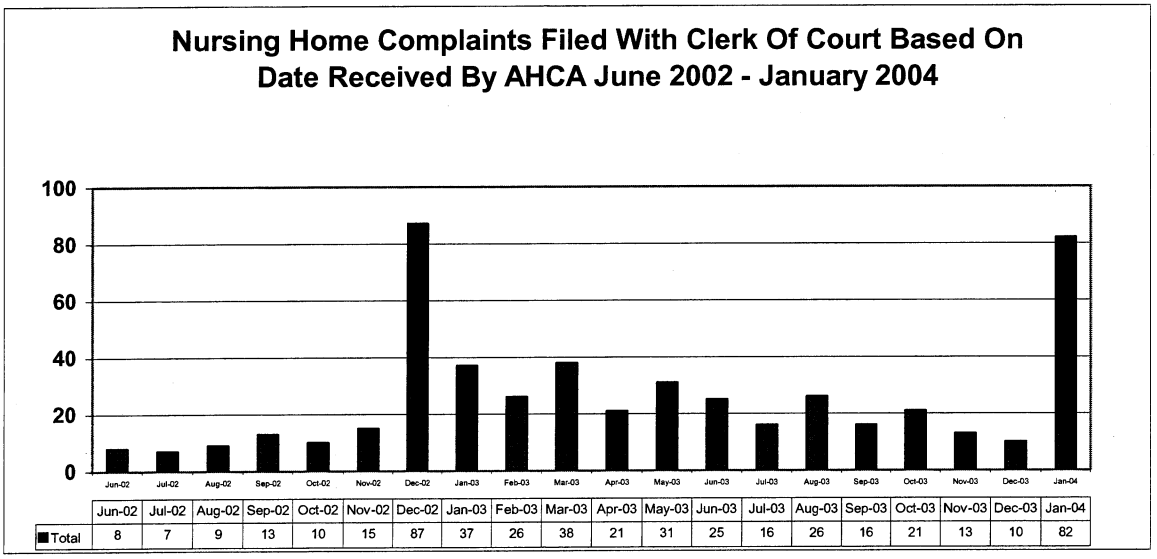
Chart 2



	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	Jan-04
Total	17	23	30	29	23	26	30	35	40	23	34	38	27	31	13	23	22	10	21	12

Data provided by AHCA shows that between June 2002 and January 2004, a total of 507 complaints have been filed against nursing homes and transmitted to the agency pursuant to s. 400.023(6), F.S., as detailed in Chart 2.

Chart 3



	Jun-02	Jul-02	Aug-02	Sep-02	Oct-02	Nov-02	Dec-02	Jan-03	Feb-03	Mar-03	Apr-03	May-03	Jun-03	Jul-03	Aug-03	Sep-03	Oct-03	Nov-03	Dec-03	Jan-04
Total	8	7	9	13	10	15	87	37	26	38	21	31	25	16	26	16	21	13	10	82

Chart 3 depicts the same data as Chart 2, although compiled by the date the report was received by AHCA. Although s. 400.023(6), F.S., requires that the complaint be served on AHCA at the same time it is filed with the clerk of the court, data in Chart 3 indicates that plaintiffs are not complying with this requirement. In addition, s. 400.147(9), F.S., required that nursing homes mail a copy of the complaint to AHCA by the tenth of the month after which it is received. Chart 3 suggests that nursing homes are not timely complying either.

Chart 4

	For-Profit	**Non-Profit**	**Multi-Facility Owner**	**Total**
Licensed Nursing Homes	509 (76%)	161 (24%)	383 (57%)	670
NH Submitting NOI	435 (80%)	104 (20%)	279 (52%)	539
Total # of NOI Submitted	2257 (87%)	315 (13%)	1286 (50%)	2572
Total # of Beds	63478 (77%)	18991 (23%)	47832 (58%)	82469
NOI per 1000 Beds	35.55	16.58	26.88	31.18
Total # of Complaints	499 (90%)	47 (10%)	305 (56%)	546
Complaints per 1000 Licensed Beds	7.86	2.47	6.37	6.62

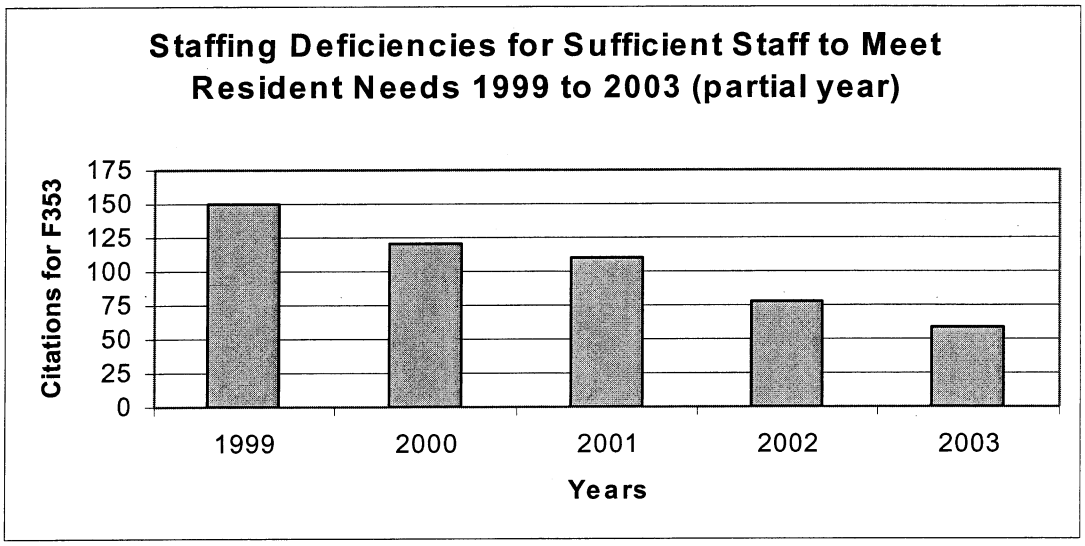
* This data may change due to late reporting by facilities.

Copies of pre-suit notices or notices of intent to sue (NOI) which are required by s. 400.0233, F.S., must also be provided to AHCA. Florida has 670 licensed nursing homes. Since the passage of SB 1202, 539 nursing homes have submitted a total of 2,572 NOIs. Chart 4 provides a breakdown of this data by ownership type.

Attachment C

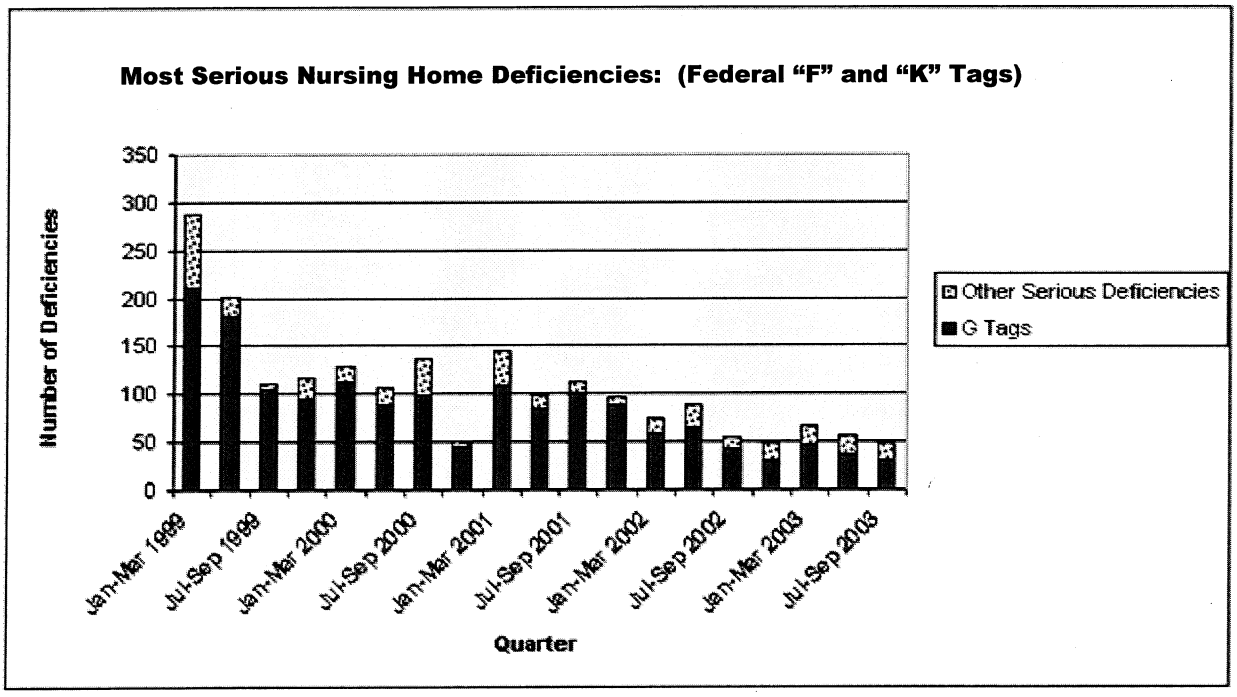
Quality of Care Data

Chart 5



State and federal laws and rules require that facilities must provide enough staff adequate to meet resident needs, regardless of any minimum staffing standards. F353 citations are those in which a facility is determined to have violated this requirement.

Chart 6



Since the implementation of SB 1202, the number of deficiencies cited at the more severe levels has gone down. Chart 6 presents a subset of all deficiencies, focusing on Immediate Jeopardy (those that have caused or had the potential to cause serious injury, harm or impairment) and Actual Harm.

Chart 7: Numbers of facilities on the AHCA "Watch List"

Reporting Period	Number of Facilities
April 1, 2001 – June 30, 2001	83
July 1, 2001 – September 30, 2001	90
October 1, 2001 – December 31, 2001	91
January 1, 2002 – March 31, 2002	84
April 1, 2002 – June 30, 2002	92
July 1, 2002 – September 30, 2002	72
October 1, 2002 – December 31, 2002	55
January 1, 2003 – March 31, 2003	63
April 1, 2003 – June 30, 2003	57
July 1, 2003 – September 30, 2003	47

Source: Agency for Health Care Administration, 2004.

Chart 8: Top three complaints to the Long-Term Care Ombudsman Program

1998	1999	2000	2001	2002	2003
Short staff	Short staff	Short staff	Short staff	Medication	Medication
Dignity	Dignity	Gross neglect	Medication	Short staff	Accidents/ falls
Personal hygiene	Dignity/ Respect	Medication	Personal hygiene	Personal hygiene	Personal hygiene

Source: Long-Term Care Ombudsman, 2004.